DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COMP	(X3) DATE SURVEY COMPLETED C	
		345013	B. WING _		l	26/2025	
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		EC	000			
F 000	investigation survey through 06/26/25. The compliance with the i	certification and complaint was conducted on 06/23/25 me facility was found in requirement CFR 483.73, lness. Event ID #GRXP11.	FC	000			
	survey was conducte 06/26/25. Event ID # intakes were investig NC00222262, NC002	complaint investigation d from 06/23/25 through GRXP11. The following ated: NC00221971, 224328, NC00224758, 230709, NC00231756 and					
F 759 SS=D	deficiency. Free of Medication E	allegations resulted in rror Rts 5 Prcnt or More	F 7	759		7/13/25	
	§483.45(f) Medication The facility must ensi						
	percent or greater;	tion error rates are not 5					
	Based on record rev interviews, the facility			F759			
	(2 medication errors resulting in a medica	ninistration of wrong dosage out of 30 opportunities), tion error rate of 6.67% for 2		Resident affected: Immediate retraining was condute Director of Nursing (DON) values #1 and Nurse #2 regarding	with the		
	observed during med	ent #105 and Resident #36) lication pass.		nurse #1 and Nurse #2 regardir medication administration and o dosages. This was completed of	correct		
	The findings included	CUDDITED DEDDESENTATIVE'S SIGNATUR		6/25/2025. On 6/25/2025, Nurs	e #1 made	(Y6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

07/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345013	B. WING		06/26/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		_		3223 CENTRAL AVENUE	
PEAK RES	SOURCES - CHARLOTTE			CHARLOTTE, NC 28205	
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	SRIATE DATE
F 759	Continued From page	2 1	F 75	9	
				dosage correction for Resident #105	<u>.</u>
	1 Resident #105 wa	s admitted to the facility on		ensuring the correct dosage of	´
		es that included vitamin		Cholecalciferol (Vitamin D3) microgi	rams
	deficiency.	55 that moladed vitalini		(mcg) (2000 units) was administered	
	denoiency.			06/25/2025, Nurse # 2 made dosage	
	The Physician's Orde	re in Resident #105's		correction for Resident #36 ensuring	
		cord indicated an active		correct dosage of Cholecalciferol (V	_
		or Cholecalciferol (Vitamin		D3) 50 mcg (2000)	itaniin
	D3) 50 micrograms (r	mcg) (2000 units) once a		,	
	day.			Resident #105 and Resident #36 we	
	0 0/05/05 1 0 40 41			adversely affected by the alleged de	ificient
		M, Nurse #1 was observed		practice.	
		administered Resident			
	#105's medications. Nurse #1 administered one Other residents with potential to be				
	tablet of Vitamin D3 2	25 mcg to Resident #105.		affected:	
		se #1 on 6/25/25 at 9:38 AM		DON observed Licensed Nurse #1 a	
		nave given two tablets of		SDC observed Nurse #2 for the rem	ıainder
	Vitamin D3 to Resident #105 when she gave her of med		of medication administration to ensu		
	medications.			other medication dosage errors. There	
				were no additional residents identifie	ed to
		Director of Nursing (DON)		have been affected by the alleged	
	on 6/25 /25 at 2:40 PI	n 6/25 /25 at 2:40 PM revealed she would need deficient practice.			
	to check to see why N				
		it was probably because she		System corrective action:	
	didn't read the label o	n the bottle carefully. The			
		nurses were supposed to		The DON and SDC will educate all	
	follow the five rights of	of medication administration.		Licensed Nurses and Medication Aid	
				(MA) on medication pass and dosag	
		admitted to the facility on		This education will be completed by	
		s that included vitamin D		7/12/2025. Any Licensed Nurses or	
	deficiency.			Medication Aides out on leave, vaca	
				PRN status will be educated by the	DON
	The Physician's Orde			or SDC prior to returning to their	
	electronic medical red	cord indicated an active		assignment. All newly hired Nurses	
	order dated 2/12/23 for	or Cholecalciferol (Vitamin		are educated on this policy and prod	
	D3) 50 mcg (2000 un	its) once a day.		during orientation by the SDC or DC	N.
				Education specifically on correct do	sage
	On 6/25/25 at 8:40 Af	M, Nurse #2 was observed		and specifically on dosage of Vitami	in D.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345013	B. WING			l	C / 26/2025
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205		1 00/	20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	Nurse #1 administered 10 mcg (400 units) to An interview with Nur revealed she was award different formulations that she should have of Vitamin D3 that had dose to Resident #36. An interview with the on 6/25 /25 at 2:40 Pl to check to see why Medication error, but didn't read the label of DON stated that the resident with the resident	Resident #36's medications. Indicate two tablets of Vitamin D3 Resident #36. See #2 on 6/25/25 at 9:11 AM are that the facility had two of Vitamin D3 available, and pulled from the other bottle d 50 mcg to give the correct Director of Nursing (DON) M revealed she would need	F	759	Monitoring: DON or SDC to audit two licensed nurs and/or medication aides using Medicat Pass Worksheet for Licensed Nursing and MA staff during medication pass on all shifts randomly twice a week for 4 week and then once weekly for 4 weeks, the biweekly x 4 weeks to ensure continue compliance. Audits will be specifically correct dosage given during medication administration. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee month	ion and ks n d on n	
	CFR(s): 483.60(i)(1)(3)(3) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe	re food from sources ed satisfactory by federal, ies. bod items obtained directly subject to applicable State	F	812	by the DON, for review and to ensure continued compliance with the plan of correction.		7/13/25

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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLOTTE STREET ADDRESS, CITY, STATE, ZIP CODE 3223 CENTRAL AVENUE CHARLOTTE, NC 28205	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - CHARLOTTE CAN ID PREFIX TAG			345013	B. WING _			_	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 3 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:					3223 CENTRAL AVENUE	E	00/20/2020	
gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETION	
facility failed to remove expired milk from the kitchen's walk-in refrigerator for 1 of 1 walk-in refrigerator. Findings included On 6/23/225 at 10:48 AM an observation of the walk-in refrigerator with the Dietary Manager (DM) found a crate located on the second shelf containing approximately 12-pint size milk cartons stamped with a expiration date of 6/17/25. On 6/25/25 at 11:19 AM the DM stated the expired milk should have been removed by the expiration date. Furthermore, the DM stated it was her refrigerator food items were not stored past their expiration date. Furthermore, the DM stated she had overlooked the milk and she checked the walk-in refrigerator daily. The Administrator was interviewed on 6/26/25 at 3:22 PM and stated the expired milk should have been removed from the refrigerator by the expiration date. All residents have the potential to be	F 812	gardens, subject to co safe growing and foo (iii) This provision do from consuming food \$483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation facility failed to remove kitchen's walk-in refrigerator. Findings included On 6/23/225 at 10:48 walk-in refrigerator w (DM) found a crate locontaining approximal stamped with a expiration date. The responsibility to ensure food items were not seen the containing approximal stamped with a containing approximal stamped with a expiration date. The responsibility to ensure food items were not seen the containing approximal stamped with a containing approximal stamped with a expiration date. The responsibility to ensure food items were not seen the containing approximation date. The responsibility to ensure food items were not seen food items	ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ance with professional ervice safety. is not met as evidenced in and staff interviews, the expired milk from the gerator for 1 of 1 walk-in AM an observation of the expired on the second shelf extely 12-pint size milk cartons extelly 12-pint size milk cartons extell was her refrigerator extell was her refrigerator externed past their expiration in the DM stated she had and she checked the walk-in expired milk should have	F8	Peak Resources Charlotte act receipt of the Statement of De and proposes this Plan of Cor the extent that the summary of factually correct and to maintate compliance with applicable rule provisions of quality of care of The Plan of Correction is submitten allegation of compliance witten allegation of compliance and the state of the state of the prepared, and served in a sammanner. No residents suffered adverse effects related to the deficient practice. On 6/23/25 the Dietary Manager dispositive Dietary D	eficiencies rrection to of findings is ain les and f residents. mitted as a ce. will provide d, procured, nitary d any alleged ger and osed of the an		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEI AND PLAN OF CORRECTION IDENTIFICATION NUM		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	345013	B. WING		06/26/2025	
NAME OF PROVIDER OR SUPPLIES	र	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RESOURCES - CHARL	OTTE	3	223 CENTRAL AVENUE		
PEAR RESOURCES - CHARL	OTTE	0	CHARLOTTE, NC 28205		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.	
F 812 Continued From	page 4	F 812	affected by the alleged deficient practic On 06/23/2025, the District Dietary manager checked all other food items the walk-in refrigerator to check the expiration date. There were no other items to be discarded. Measures/Systemic Changes: The District Dietary manager educated the Dietary Manager and all the kitcher staff on the following by 07/12/2025: Complete inspection of walk-in refriger ensure items are discarded by the expiration date. Monitoring: An audit tool was developed to ensure items in the walk-in refrigerator have be discarded by the expiration date writter the package and will be completed were by the Dietary Manager for 8 weeks. The results of the audits will be brough the Quality Assurance and Performance Improvement Committee by the respective auditors monthly x 2 months for review and further recommendation	all een n on ekly	